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Statement of H. Sally Smith, Chairman

National Indian Health Board

On the

Fiscal Year 2006 Budget for American Indian and Alaska Native Programs

February 16, 2005 – 9:30 a.m.

Senate Russell Building, Room 485

Chairman McCain, Vice-Chairman Dorgan, and distinguished members of the Senate Indian Affairs Committee, I am H. Sally Smith, Chairman of the National Indian Health Board. I am Yupik from Alaska and also represent the Bristol Bay Area Health Corporation in southwestern Alaska. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony on the President's Fiscal Year 2006 Budget for Indian Programs. Please accept my apologies for not being present to participate in this very important hearing. Due to impending obligations in Dillingham, Alaska, I was not able to travel to Washington, D.C. I have asked National Indian Health Board Executive Director J.T. Petherick to testify on my behalf.

The NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. We strive to advance the level of health care and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their area.

Indian Country is acutely aware of the funding challenges faced by the federal government. The release of the President's budget last week confirmed the reality that federal spending for all non-defense discretionary programs will be extremely limited. American Indians and Alaska Natives have long been supportive of national security efforts and will continue to do so. However, we call upon Congress and the Administration to work with Indian Country to find innovative ways to address the funding disparities that continue to hamper Indian Country's efforts to improve the health status of American Indians and Alaska Natives. Funding for the Indian Health

Service has not adequately kept pace with population increases and inflation. While mandatory programs such as Medicaid and Medicare have accrued annual increases of 5 to 10 percent in order to keep pace with inflation, the IHS has not received these comparable increases.

No other segment of the population is more negatively impacted by health disparities than the AI/AN population and Tribal members suffer from disproportionately higher rates of chronic disease and other illnesses.

Statistics from the Centers for Disease Control and Prevention (CDC) demonstrates the health problems faced by Indian Country. American Indians and Alaska Natives had the highest prevalence of obesity, tobacco abuse, cardiovascular disease, and diabetes among both men and women. Among all minority men, AI/AN men also had the highest prevalence of self-reported hypertension and high blood cholesterol levels and among women, the second highest prevalence. The survey also showed that over 80% of American Indians and Alaska Natives surveyed had one or more adverse risk factor or chronic condition while 35% had three or more. This survey by the CDC present a snapshot of the health challenges faced by Indian Country and the need for additional resources to combat these deadly diseases and risk factors.

In reviewing these poor health indicators, the statistics could be dramatically improved if more funding was available to provide even a basic level of care and to establish programs that promote healthy lifestyles.

Indian Country continuously advocates for equitable health care funding. Health care spending for AI/AN's lags far behind spending for all other segments of society. For example, per capita expenditures for AI/AN beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries and one-third of the per capita expenditures for VA beneficiaries. In fact, the federal government spends nearly twice as much money for a federal prisoner's health care than it does for an American Indian or Alaska Native.

Let's put this in real terms:

Everyone recalls the tragic bombing in Oklahoma City and one of the co-conspirators, Terry Nichols, will spend the rest of his life in federal prison and he will receive adequate, guaranteed health care for the rest of his life. On the other hand, a young native infant will receive about half of the health care that Mr. Nichols will receive.

Also, we all remember the horrific acts of September 11th. While nearly all of the perpetrators perished as they committed those terrorist acts, a co-conspirator by the name of Zacarias Moussaoui is currently in federal custody awaiting trial for his role in the attacks. If he were to require medical attention, he would receive it. When an American Indian or Alaska Native elder requires medical care, they may not receive it, or if they do, it will be at substandard levels.

At this point in my testimony, I would like to illustrate the challenges we face as Tribal leaders as we desperately fight to improve the status of our people.

According to the Indian Health Service, American Indians and Alaska Natives have a life expectancy six years less than the rest of the U.S population. Rates of cardiovascular disease among American Indians and Alaska Natives are twice the amount for the general public, and continue to increase, while rates for the general public are actually decreasing. American Indians die from tuberculosis at a rate 500 percent higher than other Americans, and from diabetes at a rate 390 percent higher.

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, Tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of appropriated funding sufficient to advance the level and quality of adequate health services for American Indians and Alaska Natives. Recent studies reveal that almost 20% fewer American Indian and Alaska Native women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and alcohol and illegal substance consumption during pregnancy.

The greatest travesty in looking at the deplorable health of American Indians and Alaska Natives comes in recognizing that the vast majority of illnesses and deaths from disease could be prevented if additional funding was available to provide even a basic level of care.

American Indians and Alaska Natives are naturally healthy people. However, over time, the introduction of disease, social ills, an interrupted way of life, and colonization of the Americas and subsequent federal policy have created a crisis in Indian country that has left us with staggering rates of preventable conditions.

In Alaska, the climate and topography is not conducive to fermentation, therefore alcoholic substances did not become part of the lives of Alaska Natives until such substances were introduced by non-native settlers. For American Indians, fermented substances and tobacco were used for very limited/ceremonial purposes only and were not habit forming nor abused.

Federal land policies relating to American Indians and Alaska Natives have removed or greatly reduced opportunities for traditional subsistence, which have led to the lack of jobs, educational resources, food sources, etc. In an effort to assist suffering American Indian/Alaska Natives communities with food, the United States Department of Agriculture (USDA) provides foods through its commodity program; however such foods are heavily laden with sugar, fat and other ingredients that have had a detrimental effect on the rates of diabetes and obesity in Indian Country.

From the 1600's to the early 1900's, we were almost wiped out of existence by infectious disease, but through the hard work of the federal government and Tribal

governments, dramatic steps were taken to better manage the incidence and effects of small pox, tuberculosis, and others. Now, the largest threat to our existence is chronic disease; among them are heart disease, cancer, and diabetes, as well as behavioral health issues of depression and alcohol and substance abuse. Additionally, we are losing our youth at alarming rates due to suicide and unintentional injuries.

We want to find solutions to fix the health problems we face in Indian Country. It will take an investment in promoting the health and wellness of American Indians and Alaska Natives and in the Indian health care system to accomplish this goal.

The President's FY 2006 IHS Budget Request

The IHS FY 2006 requested budget authority is $3.048 billion, an increase of $63 million over the FY 2005 enacted amount for the Indian Health Service. This continual under-funding of the Indian Health Service is felt in our communities through diminished health and well-being, as well as higher mortality rates than the rest of the population.

For the past eight years, the Indian Health Service has conducted budget consultation sessions and Tribal leaders have developed a "Needs-Based Budget" for Indian Health Service funding. The needs-based budget is developed through a careful and deliberate process to ensure that it is reflective of the health needs of Indian Country.

During the development of the needs-based budget, the Office of Management and Budget (OMB) indicated the medical inflation rate will be 1.7% and the non-medical inflation rate will be 3.5% in FY 2006. The inflation estimate that was calculated using the OMB-allowed medical inflation rates is insufficient to address the actual inflationary costs experienced by the Indian Health Service and Tribally operated health programs. The resources needed to address the true rate of medical inflation for AI/AN are vital for programs dependent on contract health services (CHS). The CHS program is most vulnerable to inflation pressures, as well as pharmaceutical costs. Additional funding is needed just to maintain current services.

The "Needs-Based Budget" developed for FY 2006 documents the IHS health care funding needs at $19.7 billion. The FY 2006 budget request amount of $3.048 billion falls well short of the level of funding that would permit American Indian and Alaska Native programs to achieve health and health system parity with the majority of other Americans.

As we have carefully reviewed the President's FY 2006 IHS Budget Request, the intent of the Administration and the Indian Health Service is clear and admirable. In light of the difficult fiscal situation the federal government is facing, the Administration and IHS worked diligently to craft a budget request that reflects the priorities set forth by American Indian and Alaska Native Tribal governments during the FY 2006 Budget Consultation sessions. Tribal leadership identified several priorities and the top of the list indicated the need for additional funding to address inflation and population increases. While we commend such efforts and realize the Indian Health Service fared

quite well compared to other agencies, the Indian Health Service and Tribal governments providing health care services cannot begin to provide adequate health care with a 2.1% funding increase, especially considering inflation and, according to information provided by the National Center for Health Statistics, birth-death records indicating that the American Indian and Alaska Native population is increasing at 1.7% per year. The 1.7% population increase translates to approximately 70,000 new patients entering into the Indian Health care system annually.

Several provisions within the request would seriously affect the agency's ability to carry out its responsibilities pertaining to the health and welfare of American Indians and Alaska Natives. I will briefly discuss several of these provisions, but at this point it is imperative that Congress consider the dire need to exempt the Indian Health Service from any and all rescissions to appropriated funds. In FY 2005, the Indian Health Service Appropriated amount was reduced twice, once by over $17 million, and a second reduction in excess of $24 million. Given that the Indian Health Service, along with the Department of Defense and the Veterans Health Administration, are direct health care providers and should be exempt from rescissions, we ask the Committee members, as advocates for Indian Country, support exempted IHS from any rescissions.

Health Facility Construction: The FY 2006 budget request includes a staggering decrease in excess of $85 million for health care facilities construction (HCFC), leaving only $3.32 million in the entire health care facilities budget. The remaining funds will be used for the construction of staff quarters at Fort Belknap, Montana. While the facilities at Fort Belknap are sorely needed, the rest of Indian country has equally critical facility construction needs.

This section of the budget includes construction of new facilities, such as inpatient hospitals, outpatient hospitals, staff quarters for health professionals, regional treatment centers and joint venture construction programs. It also includes the small ambulatory program and the construction of dental facilities. These elements constitute the entire physical infrastructure of the health care delivery system in American Indian and Alaska Native communities. The proposal reflects a desire to institute a "one year pause in new health care facilities construction starts in order to focus resources on fully staffing facilities that have been constructed and are opening in Fiscal Years 05 and 06." While the goal of achieving full staffing in American Indian and Alaska Native clinics and hospitals is commendable, and one we support, disease processes and illnesses do not take a "pause." Funding to provide adequate facilities to address disease and illness for Native Peoples cannot afford to take a "pause." Stalling health care construction for one year, if it indeed is only for one year, will achieve a setback from which it will take Indian Country a decade to recover. Additionally, the Program Assessment Rating Tool (PART) for FY 2006 measured the IHS HCFC program as "effective," which is an indication that the HCFC program is an effective use of federal resources. The Indian Health Service has taken many steps to operate in an efficient manner and cutting programs that utilize federal dollars responsibly serves as a disincentive.

We request that Congress support the physical health care delivery system in American Indian and Alaska Native communities by restoring this funding level at the 2004 level of $94,544,600.

Contract Health Service Funding: The President's Budget Request includes $525 million, which provides an additional $26.9 million over last year's budget request for Contract Health Services. While we are very thankful for any increase, the proposed level of funding remains so limited that only life-threatening conditions are normally funded. In most other cases, failure to receive treatment from providers outside the IHS and Tribal health system forces people in Indian country to experience a quality of life that is far below the level normally enjoyed by non-Indian Americans.

The documented need for the Contract Health Service Program in Indian Country exceeds $1 billion: this budget would put us a little more than half way to the goal. At present, less than one-half of the CHS need is being met, leaving too many Indian people without access to necessary medical services. We recommend an increase of at least $175 million, which would raise American Indian and Alaska Native tribes to approximately 60 percent of need.

Sanitation Construction: The President's budget includes a $1,752,000 increase, with a total request of $93,519,000 for sanitation construction. This increase represents a less than one percent increase over the FY 2005 enacted appropriations. In the President's previous budget, the increase to this program was just under 10 percent. NIHB testified before this committee last year that this increase was appreciated and demonstrated the Administration's commitment to providing safe water and waste disposal to an estimated 22,000 homes. While we understand that the federal government is facing some very real and tough funding decisions, only about 1 percent of US homes lack safe water in the home, while nearly 12 percent (or approximately 36,000) of all American Indian and Alaska Native homes lack safe drinking water in the home. Proper sanitation plays a considerable role in the reduction of infant mortality and deaths from gastrointestinal disease such as acute diarrhea and infections, in Indian Country.

Lack of proper sanitation facilities was a top concern, internationally, for victims of the Tsunami disaster, and with good reason. We ask Congress to pay attention to this need and increase funding for sanitation construction to $100,000,000. This figure represents less than a ten percent increase over FY05 levels and is badly needed in Indian Country.

Contract Support Costs: The President's FY 2006 Budget Request includes a $5 million increase in contract support costs. We understand that these are difficult budgetary times and that this increase represents successful efforts on behalf of the Administration and Tribal Leadership to increase funds for contract support costs. In that spirit of appreciation, it also must be stated that the demonstrated need for contract support costs is in excess of $100,000,000 over appropriated levels. The President's request of a $5 million increase is the first step and we request that Congress continue to seek

opportunities to advance this effort and provide the necessary resources to Tribal governments operating their own health care systems

This funding is critical to supporting tribal efforts to develop the administrative infrastructure gravely necessary to successfully operate IHS programs. An increase in Contract Support Costs is necessary because as Tribal governments continue to assume control of new programs, services, functions, and activities under Self-Determination and Self-Governance, additional funding is needed. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over direct service programs. Failure to adequately fund Contract Support Costs is defeating the very programs that appear to be helping improve health conditions for American Indians and Alaska Natives.

We strongly urge reconsideration of this line item in the proposed budget. As Tribes increasingly turn to new Self Determination contracts or Self Governance compacts or as they expand the services they have contracted or compacted, funding necessary to adequately support these is very likely to exceed the proposed budgeted amount. We ask you to fund contract support costs at a level that is adequate to meet the needs of the Tribes and to further the important Trust responsibility charged to the federal government. We recommend an additional $100 million to meet the shortfall for current contracting and compacting, and to allow for funding in anticipation of the 20-25 additional Tribal programs anticipated.

Tribal Management/Self-Governance Funding: According to the President's FY 2006 Budget Request, the number of tribally managed IHS programs continues to increase, both in dollar terms and as a percentage of the whole IHS budget. Tribal governments will control an estimated $1.8 billion of IHS programs in FY 2006, representing 56 percent of the IHS's total budget request. Because of this, it is critical that funding for self-governance be provided in a manner reflective of this. Therefore, we feel it is necessary to provide funding over and above the proposed amount of $8 million. The FY 2003 budget cut the office of Self-Governance funding by 50% without any notice to tribes. The enacted budget for FY 2004 and the proposed FY 2005 budget both fail to increase the funding beyond $8 million enacted from FY 2003. For Tribal governments to continue managing IHS programs and other Direct Service Tribes to consider compacting, we ask that funding for self-governance be increased to $20 million.

Special Diabetes Program for Indians (SDPI): The Special Diabetes Program for Indians is growing into a success story. It's developing a community spirit and Tribal governments and communities are working together in a proactive approach to combat diabetes. The recently-submitted report to Congress shares many of the advancements Indian Country has made in the areas of: Increased prevention activities; Increased treatment; Integrated prevention and treatment activities in culturally appropriate methods and by a multidisciplinary approach; Improved Data; Information Sharing and Best Practices; Utilizing Tribal Consultation; and Developing partnerships with the non-Indian community to combat diabetes. Congress and IHS worked with Tribal Leaders to make this program possible and we stand committed to seeing it made a permanent

fixture in American Indian and Alaska Native Communities. The SDPI is a program that needs to be replicated in Indian Country to combat other chronic disease and preventable maladies.

A recent survey by the Centers for Disease Control (CDC) demonstrates the health problems faced by American Indians and Alaska Natives. The CDC contracted with the National Opinion Research Center at University of Chicago to conduct the REACH 2010 Risk Factor Survey. The survey was conducted during June 2001--August 2002 in 21 minority communities in the United States, two of which included 1,791 American Indians who participated in the survey. American Indians had the highest prevalence of obesity, current smoking, cardiovascular disease, and diabetes among both men and women in these four groups. Among all minority men, American Indians also had the highest prevalence of self-reported hypertension and high blood cholesterol levels. Among women, American Indians had the second highest prevalence. The survey also showed that over 80% of Americans Indians surveyed had one or more adverse risk factor or chronic condition while 35% had three or more. This survey by the CDC represents the health challenges faced by Indian Country and the need for additional resources to combat these deadly diseases and risk factors.

As the CDC survey demonstrates, the prevalence of chronic diseases such as cardiovascular disease in Indian Country is increasing and requires immediate attention. Due to a lack of adequate preventative care and education for American Indians and Alaska Natives, heart disease has become the leading cause of death among American Indians and Alaska Natives according to the CDC's 1997 report on cardiovascular disease risk factors. The prevalence of risk factors such as hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes among American Indians and Alaska Natives needs to be addressed. As such, the Indian Health Service and Tribal health centers must receive additional resources to aggressively treat the risk factors and improve the overall health and well being of American Indian and Alaska Native communities.

Cardiovascular disease is also the leading cause of death among American women according to the American Heart Association. The prevalence of this disease among American Indian and Alaska Native women will continue to grow if steps are not taken to prevent hypertension, obesity, high cholesterol, poor diet and lack of exercise, which all combine to put a woman at risk for a heart attack or other coronary event. In 2001, the CDC addressed this problem through its WISEWOMAN demonstration projects. WISEWOMAN stands for Well-Integrated Screening and Evaluation for Women Across the Nation. The WISEWOMAN program provided low-income, under insured, and uninsured women aged 40-64 years in 12 different states with chronic disease risk factor screening, lifestyle intervention, and referral services in an effort to prevent cardiovascular disease. In southern Alaska and South Dakota, the program focused on screening for American Indian and Alaska Native women. This type of project is still needed on a permanent basis in the Indian Health Service and Tribal health clinics.

Along with cardiovascular disease, diabetes, obesity and cancer increasingly affects American Indian and Alaska Native communities. According to a CDC report in 1998, lung, colon, prostate and breast cancers constituted 53% of all cancer-related deaths in the United States. The report compared cancer-related deaths by gender and race/ethnicity from 1990-1998. While generally concluding that death rates from these cancers declined among men and women in the United States, lung cancer in women and lung, colorectal, and breast cancer in American Indians and Alaska Natives. Among men, death rates from lung and bronchus cancer decreased 1% to 2% per year for each race/ethnicity except American Indians and Alaska Natives. Among American Indians and Alaska Natives, death rates increased 1.7% per year among men and 2.9% per year among women. The report concluded that increases in death rates for American Indians and Alaska Natives most likely reflected increases in smoking rates. American Indians and Alaska Natives have among the highest smoking rates in the United States according to a report issued by the Centers for Disease Control on January 30, 2004. Considering the prevalence of numerous risk factors for chronic diseases and the under funding of our health systems for preventative care, we ask Members of Congress to provide critical preventative health resources to help build up our communities. We cannot build a strong future for the coming generations if we continue to lose our population to these devastating illnesses.

In response to the dire need for increased efforts for health promotion and disease prevention activities throughout Indian Country, the National Indian Health Board recently approved Resolution 2005-01 which supports increased funding in the amount of $200 million annually for the Indian Health Service: this funding would constitute the WIN! (Well Indian Nations) Initiative. The resolution directs that such funds be recurring, are disbursed in a non-competitive manner, and do not adversely affect the annual appropriations of the Indian Health Service.

Homeland Security Funding in Indian Country

The President's FY 2006 budget request for the Department of Health and Human Services (DHHS) reflects the priorities of the United States with regard to health and safety concerns relating to Homeland Security. It reflects the Administration’s commitment to anticipating future threats to America's public health care, health infrastructure and human services systems. It is important to note that, along with the Department of Defense and Veteran’s Affairs health systems, the Indian Health Service occupies a unique position within the Federal government as a direct health care provider.

Therefore, we are requesting that Congress add funding during FY 2006 to help the Indian Health Service and Tribal governments prepare for and respond to potential terrorist attacks, including increases for Data Systems Improvements.

Conclusion

In closing, the Indian Health Service sets the standard for convening and utilizing Tribal consultation in the development of Budget recommendations. Additionally, with the recent signing of the Secretary of Health and Human Services Tribal Consultation Policy, we look forward to other operating divisions doing the same.

On behalf of the National Indian Health Board, I would like to thank the Committee for its consideration of our testimony and for your interest in the improvement of the health of American Indian and Alaska Native people. If we are to reduce the terrible disparities between the health of American Indians and Alaska Natives compared to other Americans, we need to properly fund the Indian Health Service and we urge the Senate to significantly increase the IHS funding level during this fiscal year. IHS and the Tribes are continuing to work diligently to develop health systems of sufficient quality and with levels of services that our people desperately need. We look forward to working with you on this budget.